

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



Official CMS Information for  
Medicare Fee-For-Service Providers

# Inpatient Rehabilitation Facility Prospective Payment System

## PAYMENT SYSTEM FACT SHEET SERIES





**T**his publication provides the following information about Inpatient Rehabilitation Facilities (IRF):

- ❖ Background;
- ❖ Elements of the IRF Prospective Payment System (PPS);
- ❖ Quality reporting; and
- ❖ Resources.

## Background

Section 4421 of the Balanced Budget Act of 1997 (Public Law 105-33) modified how payment is made for IRF services by creating Section 1886(j) of the Social Security Act (the Act), which authorized the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals—referred to as IRFs. The IRF PPS payment for each patient is based on information found in the IRF patient assessment instrument (PAI), which contains patient clinical, demographic, and other information, and classifies the patient into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments.

## Elements of the Inpatient Rehabilitation Facility Prospective Payment System

The IRF PPS includes the following elements:

- ❖ Rates;

- ❖ Classification criterion; and
- ❖ Reasonable and necessary criteria.

Each element is discussed in more detail below.

## Rates

As required by Section 1886(j) of the Act, the Federal rates reflect all costs of furnishing IRF services (routine, ancillary, and capital related) other than costs associated with operating approved educational activities as defined in the “Code of Federal Regulations” (CFR) under 42 CFR 413.75 and 413.85, bad debts, and other costs not covered under the PPS. Federal rates are adjusted to reflect:

- ❖ Patient case mix, which is the relative resource intensity that would typically be associated with each patient’s clinical condition as identified through the resident assessment process:
  - Cases are grouped into Rehabilitation Impairment Categories, according to the primary condition for which the patient was admitted to the rehabilitation hospital;
  - Cases are further grouped into case-mix groups (CMG), which group cases that are similar according to their functional motor and cognitive scores and age;
  - Finally, cases are grouped into one of four tiers within each CMG, according to patients’ comorbidities (conditions that are secondary to the principal diagnosis or reason for the inpatient stay). Each tier adds a successively higher payment amount to the case depending on





whether the costs of the comorbidity are significantly higher than other cases in the same CMG (low, medium, or high); and

- Additional adjustments are made for interrupted stays, short stays of less than three days, short-stay transfers (defined as transfers to another institutional setting with an IRF length of stay less than the average length of stay for the CMG), and high-cost outlier cases; and

#### ❖ Facility characteristics:

- Rates are adjusted to reflect geographic differences in wage rates, using the hospital wage index;
- IRFs in rural areas (non-Metropolitan Statistical Areas) receive an increase to their rates;
- IRFs receive an increase to their rates depending on the proportion of low-income patients they treat; and
- IRFs with residency training programs receive an increase to their rates that is based on the number of interns and residents they train compared with their average daily census. This adjustment is subject to a cap.

Federal rates are updated annually:

- ❖ To reflect inflation in the cost of goods and services used to produce IRF services, using a market basket index that is calculated for IRFs, Long-Term Care Hospitals, and Inpatient Psychiatric Facilities (facilities originally excluded from the Acute Inpatient PPS);
- ❖ To reflect changes in local wage rates, using the hospital wage index; and
- ❖ Through rulemaking that, by law (Section 1886(j) of the Act), must be provided for publication in the “Federal Register” on or before the August 1 that precedes the October 1 start of each new Federal fiscal year (FY).

## Classification Criterion

In order to be excluded from the Acute Inpatient PPS specified in 42 CFR 412.1(a)(1) and instead be paid under the IRF PPS, an inpatient rehabilitation hospital or rehabilitation unit of an acute care hospital must meet the requirements for classification as an IRF stipulated in subpart B



of 42 CFR part 412. One criterion specified at 42 CFR 412.23(b)(2) that Medicare uses for classifying a hospital or unit of a hospital as an IRF is that a minimum percentage of a facility’s total inpatient population must meet at least one of 13 medical conditions listed in 42 CFR 412.23(b)(2)(ii). This minimum percentage is known as the compliance threshold. The compliance threshold was 75 percent prior to the Centers for Medicare & Medicaid Services (CMS) issuing a final rule on May 7, 2004, which revised 42 CFR 412.23(b)(2). As 42 CFR 412.23(b)(2) previously stipulated that the compliance threshold was 75 percent, the regulatory requirement was commonly referred to as the “75 percent rule.” Beginning July 1, 2006, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) stipulated that the compliance threshold should be set no higher than 60 percent. Thus, we now refer to this regulatory requirement as the “60 percent rule.”

The Medicare, Medicaid, and SCHIP Extension Act of 2007 also stipulated that comorbidities that meet certain criteria as specified in 42 CFR 412.23(b)(2)(i) must continue to be used to determine the compliance threshold, as they have been since the May 7, 2004, final rule.

The 13 medical conditions that qualify for the 60 percent rule, as specified in the May 7, 2004, final rule, are:

- ❖ Stroke;
- ❖ Spinal cord injury;
- ❖ Congenital deformity;
- ❖ Amputation;
- ❖ Major multiple trauma;

- ❖ Fracture of femur (hip fracture);
- ❖ Brain injury;
- ❖ Neurological disorders including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease; and
- ❖ Burns.

For the three qualifying conditions listed below, the severity/complexity can vary significantly. For this reason, additional clinical criteria have been established to require evidence that other less intensive treatments have been attempted before admission to the IRF.

- ❖ Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living;
- ❖ Systemic vasculidities with joint inflammation resulting in significant functional impairment of ambulation and other activities of daily living; and
- ❖ Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more weight bearing joints (elbow, shoulders, hips, or knees but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, and significant functional impairment of ambulation and other activities of daily living.

For the final qualifying condition, patient characteristics have been identified which would add complexity in a way that would justify IRF level care.

- ❖ Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:
  - The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission;
  - The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; or
  - The patient is age 85 or older at the time of admission to the IRF.

## Compliance Percentage

A provider's compliance percentage is the percentage of its total inpatient population that met at least one of the medical conditions listed at 42 CFR 412.23(b)(2)(ii). The Fiscal Intermediary (FI) or A/B Medicare Administrative Contractor (MAC) uses data from a specific time period known as the compliance review period to calculate a compliance percentage. The compliance review periods associated with different cost reporting periods are specified in a detailed table that can be found in the "75 percent rule" Program Transmittals, which can be accessed at <http://www.cms.gov/Transmittals> on the CMS website. The FI or A/B MAC computes a percentage by either:

- ❖ The Presumptive Method – Using a CMS software program that analyzes the IRF PPS impairment group, etiologic, or comorbidity ICD-9-CM codes on the IRF PAIs that the provider submitted to CMS during a specific compliance review time period; or
- ❖ A Review of Medical Records – Analyzing a random sample of medical records that represent inpatients the IRF treated during the compliance review time period.

Although the FI or A/B MAC may determine that the provider met an applicable compliance threshold by using the presumptive method, the FI or A/B MAC still has the discretion to also use a random sample of medical records to calculate a compliance percentage. A compliance percentage calculated by the FI or A/B MAC analyzing a random sample of medical records will always supersede a compliance percentage calculated by using the presumptive method. Also, the FI or A/B MAC must use the random sample medical record method to calculate







the compliance percentage when the compliance percentage using the presumptive method fails to meet the applicable compliance threshold.

The FI or A/B MAC is responsible for notifying the appropriate CMS Regional Office (RO) of the results. Based on this information, the RO is responsible for determining the provider's classification status prior to the start of the provider's next cost reporting period. The classification status of a provider as an IRF must be determined at the beginning of its cost reporting period and is effective for the entire cost reporting period. When a provider is not classified as an IRF, it is not eligible to be paid under the IRF PPS and may instead be paid under the Acute Inpatient PPS or, if applicable, the payment system Medicare uses to pay Critical Access Hospitals provided that it meets all of the requirements to be paid under one of these other payment systems.

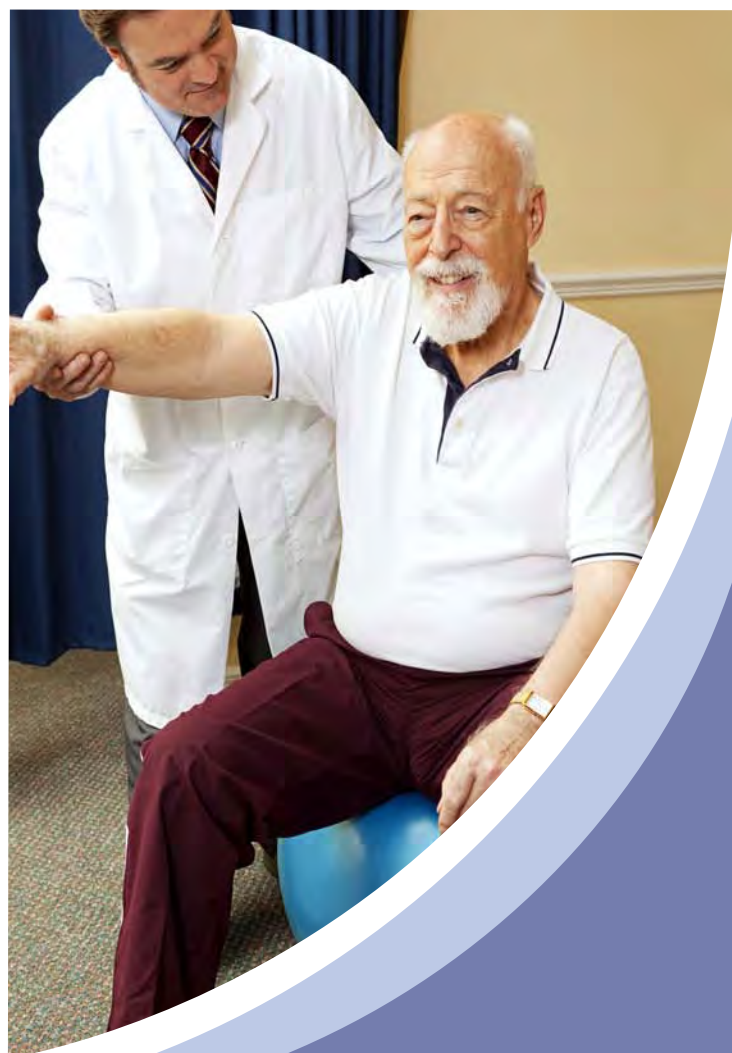
### **Reasonable and Necessary Criteria**

The following coverage requirements, which determine whether individual IRF claims are for reasonable and necessary services under Section 1862(a)(1) of the Act, are effective for discharges that occur on or after January 1, 2010:

- ❖ Outline the key decision points that should be considered and documented when making a decision to admit, retain, or discharge an IRF patient;
- ❖ Specify certain preadmission assessment requirements and eliminate the 3 to 10 day post-admission assessment period;
- ❖ Require a post-admission physician evaluation to verify that the beneficiary's preadmission

assessment information remains unchanged or to document any changes;

- ❖ Specify requirements for an individualized overall plan of care for each beneficiary;
- ❖ Emphasize the interdisciplinary approach to care provided in IRFs and increase the required frequency of interdisciplinary team meetings to reflect the compressed average length of stay in IRFs today compared with prior decades; and
- ❖ Clarify the requirements for admission to an IRF by specifying that a beneficiary must:
  - Be sufficiently medically stable to benefit from IRF services;
  - Need the coordinated care of multiple therapy disciplines uniquely provided in IRFs;
  - Benefit from the intensity of rehabilitation therapy services uniquely provided in IRFs; and
  - Require close medical supervision for the management of medical conditions to support participation in an intensive rehabilitation therapy program.





## Resources

To find additional information about the IRF PPS refer to Chapter 1, Section 110, of the “Medicare Benefit Policy Manual” (Publication 100-02) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find further IRF PPS information and a link to Federal regulations, visit <http://www.cms.gov/InpatientRehabFacPPS> on the CMS website. To find the compilation of Social Security laws, visit [http://www.ssa.gov/OP\\_Home/ssact/title18/1800.htm](http://www.ssa.gov/OP_Home/ssact/title18/1800.htm) on the U.S. Social Security Administration website. To find CFR citations, refer to the CFR located at <http://www.gpo.gov/fdsys/search/home.action> on the U.S. Government Printing Office website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.

## Quality Reporting

Per Section 1886(j)(7)(A)(i) of the Act, beginning in FY 2014, quality data must be reported for the following events that occur in the IRF setting:

- ❖ Urinary catheter-associated urinary tract infections (CAUTI) events on all patients; and
- ❖ Percent of Medicare patients with new or worsened pressure ulcers.

IRFs that do not report the quality data will be subject to a 2 percentage point reduction to the applicable market basket increase beginning in FY 2014.

The initial reporting period will be for CAUTI and new or worsened pressure ulcer events that occur from October 1, 2012, through December 31, 2012. All subsequent IRF quality reporting cycles will be based on a full calendar year (January 1 through December 31 of the applicable year).

The new or worsened pressure ulcer data will be reported through the IRF PAI. To find additional information about the revised IRF-PAI form that will be used beginning October 1, 2012, visit [http://www.cms.gov/InpatientRehabFacPPS/04\\_IRFPAI.asp](http://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp) on the CMS website.

Additional information about data submission and reporting requirements for these quality measures will be published no later than January 31, 2012, at <http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting> on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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